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JOINT COMMITTEE ON FINANCE

MEMORANDUM

To: Members
Joint Committee on Finance

From: Senator Lena Taylor
Representative Robin Vos

Date: July 18, 2012

Re: DHS Paper to JFC

Attached is a paper providing an update on Wisconsin's Family Care and related long-term care programs with regard to the enrollment cap that was in place July 1, 2011 through April 3, 2012, from the Department of Health Services, received on July 18, 2012.

This report is being provided for your information only. No action by the Committee is required. Please feel free to contact us if you have any questions.

Attachments

LT:RV:jm

State of Wisconsin
Department of Health Services

Scott Walker, Governor
Dennis G. Smith, Secretary

April 17, 2012

Honorable Alberta Darling, Senate Co-Chair
Joint Committee on Finance
Room 317 East, State Capitol
P. O. Box 7882
Madison, WI 53707-7882

Honorable Robin Vos, Assembly Co-Chair
Joint Committee on Finance
Room 309 East, State Capitol
P. O. Box 8953
Madison, WI 53708-8953

Dear Senator Darling and Representative Vos:

The attached paper provides an update on Wisconsin's Family Care and related long-term care programs with regard to the enrollment cap that was in place from July 1, 2011 through April 3, 2012, as well as the steps that the Department of Health Services is taking related to enrolling people who are both functionally and financially eligible into these programs.

This paper describes our efforts to expedite enrollment, to build on the health care services and LTC supports provided during the period of the cap, and to implement savings initiatives that ensure LTC services are cost-effective and fiscally sustainable.

Please contact me if you have any questions.

Sincerely,

Dennis G. Smith

Dennis G. Smith
Secretary

Attachment

Wisconsin's Family Care Program—Lifting the Temporary Caps and Putting the Program on the Path to Long Term Sustainability

Overview

Wisconsin continues to lead the nation in developing effective strategies to address the needs of individuals who rely on public assistance for long-term care (LTC), services, and supports. In total, LTC expenditures will exceed $2.8 billion (all funds) this year, representing about 40% of the State's Medicaid budget. Over the years, Wisconsin has developed a number of optional programs that offer individuals alternatives to the institutionally-based mandates of Medicaid. The State has employed a series of innovative Medicaid waivers to diverge from traditional Medicaid requirements. Family Care is the largest of these programs under the Medicaid umbrella that is designed to serve low-income adults who have a disability or are frail and elderly.

In 2011, two coincident and significant events resulted in a slowing of enrollment into Family Care. First, in April, the nonpartisan Joint Legislative Audit Bureau released its widely anticipated comprehensive audit of the Family Care program as directed by the Legislature in July 2010. While the evaluation documented the popularity of the program and the strong support of a wide range of its members and stakeholders, critical questions were raised regarding the cost-effectiveness and fiscal sustainability of the Family Care program. As a result, the Legislature directed the Department of Health Services (DHS) to study the cost-effectiveness of our LTC programs.

Second, on July 1, 2011, the State experienced a massive reduction in federal funding for its Medicaid program. The loss of $660 million in federal funds for Fiscal Year 2012 and an additional $666 million for FY 2013 imposed an unequivocal threat to the state's ability to sustain the innovative, yet optional LTC programs. Anticipating both of these events, Governor Walker and the Legislature provided an infusion of $1.2 billion in new state funds during the current biennium, to continue enrollment into Family Care and IRIS at existing levels and to support individuals who were in urgent/emergency need of publicly-funded long term support services. The 2011-13 biennial budget, 2011 Wisconsin Act 32, created a temporary enrollment cap for the Family Care, IRIS, PACE and Partnership programs.

It is important to note that the State could have chosen to scale back these waiver programs by reducing benefits. This available choice was reiterated most recently by Solicitor General Donald B. Verrilli during the oral arguments in *Florida, et al. v. Department of Health and Human Services*. Solicitor General Verrilli informed the U.S. Supreme Court that the maintenance-of-effort (MOE) provisions of the Patient Protection and Affordable Care Act (PPACA) do not apply to optional benefits under Medicaid, which, of course, include benefits offered under Family Care. Moreover, as an optional waiver program, the State could have ended the existing waiver and started all over with a new waiver. Other states have used this approach to reduce waiver benefits. The Governor and Legislature, however, categorically rejected these options, choosing instead to protect the benefits to more than 43,000 low-income seniors and individuals with disabilities.

This temporary provision slowed the pace but did not end new enrollment into the State's LTC programs, including Family Care, IRIS, PACE and Partnership. The temporary slowdown was designed to provide DHS and state policymakers an opportunity to explore strategies and identify options to strengthen Wisconsin's

LTC programs. Over a six-month period, DHS completed a comprehensive data analysis and consulted with a wide range of consumers, providers, advocates, tribes, counties, and other stakeholders to identify cost drivers and seek options to improve the cost-effectiveness and future fiscal sustainability of these programs.

During this period, Governor Walker continued to express his strong commitment to Family Care and other LTC programs and publicly stated his intentions to fully resume enrollment. After a package of savings reforms was identified, the Governor called upon the Legislature to lift the temporary provisions. The LTC Sustainability Initiatives identified through this outreach and feedback will provide an estimated $80 million in state savings over the 2011-13 biennium, allowing the State to remove the enrollment cap. These strategies are also designed to ensure that the State's LTC programs are sustainable on an ongoing basis in the future.

Over this time, the Department consulted on many occasions with federal representatives at the Centers for Medicare and Medicaid Services (CMS); the Governor's recommendation to repeal the cap was consistent with discussions with federal officials. Recent communications have focused on services provided during the period of the enrollment cap, which are detailed in this paper.

On April 3, 2012, the temporary enrollment provision was removed (2011 Wisconsin Act 127). This document describes our efforts to expedite enrollment, to build on the health care services and LTC supports provided during the period of the cap, and to implement savings initiatives that ensure LTC services are provided in the most integrated and least restrictive settings in the community.

In particular, this paper will provide a description and status of current efforts, along with information on:

- What individuals experienced between July 1, 2011 and April 3, 2012;
- Wisconsin's action plan to expedite outreach and enrollment into LTC programs;
- What is the wait list, who was enrolled and what are people waiting for; and
- What are the LTC Sustainability Initiatives that generate savings and strengthen LTC programs in 2011-13 and in the future.

What Individuals Experienced Between July 1, 2011 and April 3, 2012

Throughout the period between July 1, 2011 and April 3, 2012, the State continued to serve individuals seeking public assistance for their medical needs and provided information about long term care supports and services. Every individual currently on a wait list received assistance from the State. Moreover, enrollment into the Medicaid program among the elderly, blind, and disabled populations increased every month from July 2011 through March 2012, with the exception of August 2011.

Connecting People to Services. Access into Wisconsin's long term care assistance programs for many individuals begins with Aging and Disability Resource Centers (ADRCs). About 85% of Wisconsin citizens have access to an ADRC in their community. In 2010, ADRCs responded to almost 345,000 requests for assistance, averaging nearly 29,000 per month. More than 73% of ADRC activity related to Information and Assistance. Nearly 38,000 people received services from a benefit specialist. According to the most recent survey, over 93% would recommend the ADRC to others and 90% of ADRC customers said that the ADRC was helpful or very helpful.

ADRCs are welcoming and accessible places where older adults and people with disabilities can obtain information, advice, and assistance in locating services or applying for benefits. ADRCs provide a central

source of reliable and objective information about a broad range of programs and services and help people understand and evaluate various options to make informed decisions about long-term care.

ADRCs provide personalized help in finding and connecting individuals to services that match his or her needs. ADRCs provide information and access to a wide range of services, including in-home supportive and nursing care, housekeeping and chore services, home modifications, caregiver respite, nutrition and home-delivered meals, transportation, assisted living, nursing homes, and financial assistance through Medicare, Medicaid, FoodShare and other aging and benefit programs. As the single point of access for publicly funded long-term care, ADRCs provide eligibility determinations and enrollment counseling for the state's managed long-term care and self-directed supports waivers.

ADRC staff are skilled at recognizing situations that might put someone at risk, such as the sudden loss of a caregiver, and help people to secure appropriate services. ADRCs employ multiple channels (newspaper, radio, other media; physician's offices, hospitals, assisted living and nursing homes; local government agencies; community service organizations; and consumer advocacy) to outreach to client populations. ADRCs also use a variety of approaches to maintain contact with individuals already on a wait list, and provide services by telephone, in the resource center, or in a person's own home.

Services Provided During and After the Cap. While the largest payer of all long-term care services is Medicaid at 42% of total spending, the majority of long-term care services are actually provided on an unpaid basis through a person's natural support system by their family or friends. A November 2011survey of people on the ADRC wait list confirmed the substantial natural supports people received from family and friends and the need for additional help to relieve the burden on these caregivers in the future.

Although the enrollment cap temporarily slowed the pace of LTC program growth, ADRCs continued to:

- Outreach to potential clients in the community and screen people on the wait list;
- Provide information and assistance on a wide range of LTC supports and services;
- Complete functional screens to assess needs;
- Link people to programs and services; and
- Using attrition and urgent needs funding, enroll individuals into publicly-funded LTC programs.

Wisconsin continued to meet immediate needs of people for LTC supports during the time the cap was in place. Specifically:

- ADRCs worked with individuals in need of LTC services to ensure that urgent health and safety needs were identified, and enrolled them into LTC programs using attrition and urgent/emergency funding.
- Many individuals on the wait list indicated they needed services in the future, and others are not yet financially eligible for enrollment.
- The State leveraged existing eligibility for health care programs, including Medicaid and Medicare, to provide health care, and complemented these services with resources from aging and other programs to provide supportive care, caretaker support, nutrition, chore services and transportation.
- The State provided flexibility to continue enrollment using attrition within the budget and through urgent funding. The State slowed, but did not stop new enrollment.

The budget legislation, Act 32, provided $12.6 million in each year of the biennium to meet urgent/emergency needs. On average, twelve people per month were enrolled using the additional funding provided for

urgent/emergency needs, resulting in a total expenditure of approximately $765,000. By leveraging ongoing attrition in the program and urgent/emergency funding, ADRCs were able to enroll individuals most in need of services, in addition to others on the wait list.

Information is available from a number of sources within the State's LTC and health care IT systems and through the wait list survey. To show the services received and the projected need of individuals, DHS analyzed the most recent wait list, enrollment data, and other data available as of February 2012. At that time, there were 6,263 individuals who met the functional eligibility screen requirements to be placed on the ADRC wait list. The following summarizes the status and services received of the individuals on the wait list.

- 100% of the 6,263 individuals on the wait list received a least one type of service from an ADRC.
- 98.6% were enrolled in either Medicare (46.6%) or Medicaid (52%), which provides them with access to health care services.
- 34.6% (2,167) identified a need for services in the future. Some are not likely to meet financial eligibility criteria now, or do not wish to access services now. Spend-down, cost share and estate recovery requirements are important factors in an individual's decision of whether to enroll in publicly-financed LTC programs.
- 29% (1,810) are not currently eligible due to the county phase-in of LTC programs.
- 28% (1,753) had no immediate need, some because they were already receiving services through their local aging office or other programs and supports.
- 6.9% (433) are currently in the process of enrollment using available attrition slots.
- 1.6% (100) received needed services by remaining on the State's Children's Long Term Support Waiver, and will transition to adult programs in the future.

In summary, even during the temporary period of enrollment caps, DHS administered the Family Care, IRIS and other LTC programs in a flexible manner that met the needs of our citizens.

Aggregate Enrollment and Nursing Home Data. Data on Medicaid enrollment of populations that qualify under eligibility criteria as elderly, blind or disabled (EBD) over the period of the temporary cap indicate that from June 2011 to February 2012:

- Enrollment of the total EBD population in Medicaid continued to rise from 206,512 to 211,015 individuals.
- Enrollment of the EBD population in Family Care, IRIS and legacy waivers rose from 48,222 to 48,742 people.

Some expressed concern that during this period, individuals would be forced to seek assistance for their long term care needs in institutional care. This was not the case.

- Enrollment of people in nursing homes and ICFs continued to fall from 17,735 to 17,357 individuals.
- The nursing home population as a percent of the total EBD population declined from 8.59% to 8.23%.

The following charts illustrate that from July 2011 through February 2012:

- The elderly, blind, disabled (EBD) population enrolled in Medicaid continued to grow; and
- The percentage of the EBD population in nursing homes consistently fell during the time of the cap.

Chart 1: Continued Growth in Medicaid EBD Enrollment

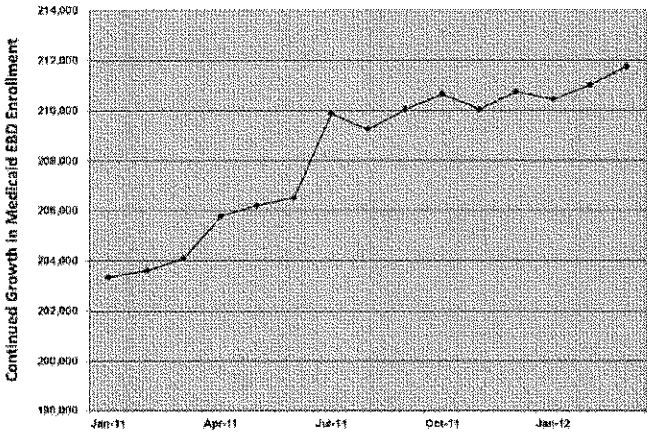
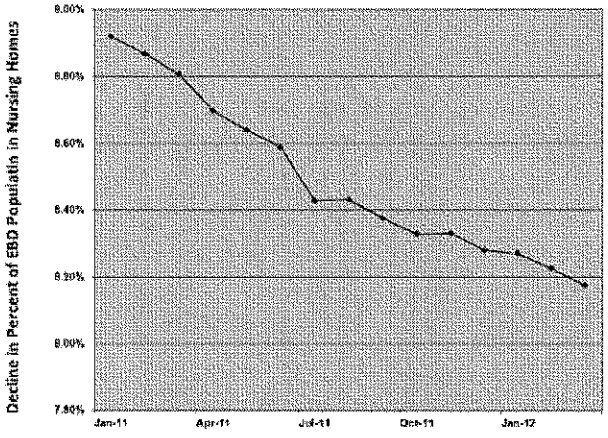


Chart 2: Decline in Percent of EBD Population in Nursing Homes



Relocations to the Community. ADRCs reported that 614 people were relocated from nursing homes and intermediate care facilities (ICFs) to the community and were enrolled into publicly-funded LTC programs from July 2011 to February 2012.

Table 1: Nursing Home and ICF Relocation Data by Month

Month	Count
July 2011	36
August 2011	57
September 2011	72
October 2011	113
November 2011	96
December 2011	116
January 2012	74
February 2012	50
Total	**614**

In addition to the data in Table 1, other nursing home and ICF residents may have been relocated to the community without ADRC assistance.

Wisconsin's Action Plan to Expedite Outreach and Enrollment into LTC Programs

The State has worked closely with the Aging and Disability Resource Centers (ADRCs), Family Care Managed Care Organizations (MCOs), the IRIS Consultant Agency, and Medicaid Income Maintenance (IM) Consortia to process functional and financial eligibility determinations and to provide options, counseling and enrollment for Family Care, IRIS, Partnership and PACE.

Significant enrollment into Wisconsin's LTC programs occurred in the months leading up to enactment of the budget legislation and, since the cap was not a freeze, ADRCs continued enrolling people into these LTC

programs after July 2011. In addition, ADRCs helped people to identify and access a variety of options to provide health care and LTC supports during the period of the enrollment cap.

Once the Governor recommended that the enrollment cap be repealed, the DHS communicated with ADRCs, MCOs, the IRIS Consultant Agency and IM to plan for the prompt and orderly enrollment of new members. This included activities, such contacting people on the wait list to assess their current status and planning with IM for prompt processing of financial eligibility determinations.

With the passage of Act 127, ADRCs and the Department's other partners have expedited processing of financial eligibility determinations, as well as options and enrollment counseling. This has resulted in increased enrollment into Family Care, IRIS, Partnership and PACE.

Specific Components of Action Plan. Currently, ADRCs are reaching out to individuals on the wait list to inform them that the enrollment cap has been repealed. This process uses established protocols that are known to be effective in communicating with frail elders and persons with disabilities. This includes contacting people by letter, phone, and through a one-on-one consultation in their own home or at the ARDC. This assures that people experience a safe, individualized approach tailored to meet their needs.

Further, in order to streamline entry into LTC programs, ADRCs facilitate the process of collecting the information needed for IM financial eligibility determinations. They also provide unbiased enrollment counseling to assure that people are enrolled into the LTC program of their choice. This includes information about spend-down, cost-sharing and estate recovery, factors that influence people's choices about enrollment in publically-funded LTC. In general, people are referred to IM for a financial eligibility determination when their income and assets are within a range to be eligible. There is no way to determine if they would have been eligible had they applied at a different point in time.

DHS Timeline and Action Plan Related to ADRC Functions

January 2012 – April 2012:

- DHS remained in close communication with the ADRCs throughout the time the cap was in place to keep abreast of wait list numbers. ADRCs provided DHS with detailed monthly wait list information by county and to assure adequate staffing and communications that are needed now that the legislation is signed into law.
- DHS provided guidance to ADRCs on the wait list, continued enrollment and use of urgent services funding, with the goal of maximizing enrollment and the use of available attrition openings.
- ADRCs continue to identify and facilitate enrollment for individuals in need of urgent services and to closely monitor data on enrollment.
- Over the last few months, ADRCs contacted individuals on the wait list to get updated information about the person's financial and functional status in order to avoid unnecessary delays once the legislation was enacted. Of the 6,263 individuals on the wait list in February 2012, an estimated 4,453 will be contacted for potential enrollment into LTC Programs. Of these, 1,327 are in the 14 counties that had reached entitlement prior to July 2011; 1,677 are in the 19 counties that reached entitlement at some point during the period of the cap; and 1,449 are in the 25 counties that are in the process of phasing into entitlement – the individuals in these counties reflect the number of people who may be eligible for enrollment at this time.

- ADRCs schedule staff home visits to provide enrollment counseling and make the referral to income maintenance as needed. This process assures continued identification of people who might need to immediately enroll into LTC. Through this process, ADRCs have also learned that many people are not interested in enrolling at this time. These are individuals who wanted the security of being on the wait list in case their current arrangements became inadequate.
- DHS has regular conference calls and meetings with all ADRCs to provide updated information on the status of enrollment to assure the process is expedited.
- DHS regional quality staff have weekly contact with each ADRC to answer questions, provide suggestions, and address issues that might pose barriers to immediate enrollment.
- As ADRCs become aware of any issues that might prevent efficient enrollment, they work with DHS staff to resolve those issues.
- DHS facilitates discussions between the ADRCs and the MCOs to help identify and resolve any issues that could affect enrollment.
- DHS facilitates discussions between the ADRCs and the IRIS Consultant Agency to help identify and resolve any issues that could affect enrollment.
- ADRCs continue to send letters and to call people on the wait list to inform them of the repeal of the enrollment cap and to schedule appointments.
- The DHS public website features information about the lifting the enrollment cap and provides guidance on contact information for ADRCs.
- ADRC websites continue to emphasize that people should contact the ADRCs if they may be in need of LTC services. This activity remained constant throughout the period of the cap.

DHS Timeline and Action Plan Related to MCO Functions

January 2012 – April 2012:

- DHS staff worked with MCO Leadership to prepare for additional enrollment by assessing staffing capacity, geographic considerations, and wait list numbers.
- DHS conducts weekly phone calls with MCOs to in order to promptly troubleshoot any issues or barriers to enrollment.
- DHS staff make individual contacts with each MCO to provide guidance and assistance with any issues, and to facilitate enrollment in each area.
- DHS staff assist with strategies to enhance care plan development, such as having the most experienced staff work with new members to create care plans.
- MCOs initiated increased hiring, expedited staff orientation and initial training to deploy new staff to work with members, and to redeploy more experienced staff to provide orientation and care management to new enrollees.

DHS Timeline and Action Plan Related to the IRIS Consultant Agency

January 2012 – April 2012:

- DHS staff worked with the IRIS Consultant Agency to prepare for additional enrollment by assessing staffing capacity, geographic considerations and wait list numbers.
- DHS conducts weekly phone calls with the IRIS Consultant Agency in order to promptly troubleshoot any issues or barriers to enrollment.

- DHS staff assist with strategies to expedite care plan development and initiate timely provision of services.
- DHS staff provide direction to the IRIS Consultant Agency to address any potential issues, such as having the higher-level Orientation Consultants work with new members to create service plans.

DHS Timeline and Action Plan Related to Income Maintenance

January 2012 – April 2012:

- DLTC and the Division of Health Care Access and Accountability (DHCAA) management and staff have frequent briefings to monitor eligibility determinations and to resolve any potential delays.
- State staff have ongoing telephone contact and meetings with the local IM agencies to discuss ways to streamline and make the financial eligibility process as efficient as possible.
- DLTC and DHCAA assure that the regionalization of IM functions enhances LTC enrollment.
- DHS staff responsible for oversight of IM activities make individual contacts with each IM Consortia to remain alert to any potential enrollment issues.

What Is the Wait List, Who Was Enrolled, and What Are People Waiting For

The enrollment cap was a temporary adjustment that slowed the pace of, but did not end, new enrollment into the State's LTC programs, including Family Care, IRIS, PACE and Partnership. ADRCs continued to ensure that all people received counseling and assistance in accessing services. People with urgent and emergency needs were identified and enrolled. There were also people who did not have urgent needs that were enrolled from the wait list.

The following sections provide information on the wait list, enrollment into the program during the cap, and what people on the wait list are waiting for.

What is the Wait List? Perhaps contrary to public perception, the wait list for Family Care does not mean all people on the wait list are eligible for the program nor is everyone in immediate need of public assistance. To be eligible for Family Care, an individual must meet both functional eligibility and financial eligibility. With the gradual implementation of Family Care and IRIS throughout the State, there was an existing wait list on July 1, 2011 since many counties were not yet at entitlement. Only 14 counties had reached entitlement before the cap was implemented.

With the phase-in of Family Care and IRIS as counties transition from the prior legacy Medicaid waivers, most counties had a wait list prior to July 2011. ADRCs enroll individuals based on state-approved wait list policies, which are "first-come, first-serve" unless the individual meets certain priority criteria. To be on a wait list, individuals must meet the functional eligibility criteria for a nursing home level of care, and meet financial eligibility criteria by the time they expect to enroll. For this reason, people on the wait list may be spending down assets to become financially eligible, or may be seeking the security of being on the list but not yet interested in starting services immediately.

In completing the long term care functional screen, ADRCs assess the needs of each individual, and address any urgent or emergency needs to ensure health and safety. ADRCs also facilitate access to health care, nutrition, caretaker support and transportation services available through Medicare and Medicaid, FoodShare,

and other aging and benefit programs. In addition, ADRCs contact people on the wait list every six months to assess any changing needs and inform individuals of their status.

Wait list policies for ADRCs during the enrollment cap mirrored existing provisions, including the criteria established for urgent/emergency needs. Under the budget legislation that implemented the cap, additional funding of approximately $12.6 million was available in each year of the biennium to fund enrollment of people on the wait list who had an urgent/emergency need for LTC services. By using attrition that occurs on an ongoing basis, along with funding for urgent/emergency needs, ADRCs continued to enroll people into Family Care, IRIS and other long-term care and health care programs during the cap. In addition, the legislation exempted from the cap any relocation to the community from a nursing home or intermediate care facility in which the individual had resided at least 90 days.

Once enrolled, Family Care MCOs or the IRIS Consultant Agency must ensure that a person-centered plan is developed and implemented for the individual.

The wait list is not static; people are added or removed because they enroll, move, pass away, or are no longer eligible. It includes frail elders and persons with developmental or physical disabilities who have met LTC requirements for functional eligibility (essentially nursing home level of care), and who are expected to meet financial eligibility for Family Care, IRIS, PACE and Partnership by the time of enrollment.
As shown in the following Table 2, the wait list totaled 6,263 people as of February 2012.

Table 2: Wait List Data by Month for Wisconsin's LTC Programs

Month	Count	Change in Count
January 2011	7,462	N/A
June 2011	5,049	-2,413
July 2011	5,378	329
August 2011	6,066	688
September 2011	6,148	82
October 2011	6,601	453
November 2011	6,740	139
December 2011	6,694	-46
January 2012	6,730	36
February 2012	6,263	-467

As Table 2 shows, the wait list totaled 7,462 in January 2011 and declined to 5,049, or by 2,413 people, in the months leading up to July 2011. As noted earlier, there was significant enrollment into Wisconsin's community-based LTC programs in advance of the provisions to slow new enrollment in July 2011. Even with this slowing, the wait list in the most recent month was almost 1,200 less than in January 2011.

ADRC Enrollment Data. ADRCs continued to enroll individuals each month during the cap. In general, ADRCs that had been at entitlement prior to the cap enrolled people within a few weeks of determining eligibility. People who had urgent needs were prioritized and enrolled.

As Table 3 illustrates, individuals were enrolled using attrition and urgent/emergency funding provided in the budget. Attrition remaining available reflects individuals in the process of enrollment (financial eligibility /

enrollment counseling / MCO and IRIS enrollment). In accounting for attrition that was in process, the actual growth in the wait list since July 2011 was 781 (Total wait list of 1,214 less 433 remaining attrition available).

Table 3: ADRC Enrollment Data by Month for Wisconsin's LTC Programs

Month	Disenrollment	Attrition Used	Moves (In/Out)	Urgent Enrollment	Urgent to Attrition	Remaining Attrition Available
July 2011	442	80	9/12	0	0	362
August 2011	476	252	16/16	2	2	224
September 2011	421	324	25/21	9	4	92
October 2011	484	407	12/22	5	1	73
November 2011	422	465	19/16	14	2	-55
December 2011	486	589	14/10	39	4	-138
January 2012	434	499	12/20	9	1	-73
February 2012	407	439	18/16	24	4	-52
TOTAL	**3,572**	**3,055**	**125/133**	**102**	**18**	**433**

ADRC Wait List Survey. When the Legislative Audit Bureau conducted their recent evaluation of Family Care, it recommended that the Department explore options to ensure that LTC services be provided in the most cost-effective manner. In November 2011, DHS surveyed potential enrollees on the wait list to better understand the timing, nature and scope of services individuals need to live well in their communities. The survey showed that:

- 81% of individuals on the wait list live in their own home, apartment, or relative's home.
- Most individuals want to stay where they now live once they enroll in Family Care or IRIS.
- Many individuals receive support from family and friends now, but additional supports are needed.
- The top LTC services requested include help with laundry/chore services, meal preparation, supportive/personal care (including care in assisted living facilities), and transportation.
- 51% indicated they get help now from family, friends, neighbors or other programs, such as SSI, Medicare, Medicaid, and for food, nutrition and meals. Of those who do not receive help now, 24% 'manage' with the help of family, 14% are doing 'okay,' and 3% manage with difficulty.
- One-third of the people on the wait list indicated that they need help in the future, not now.

What Are the Long Term Care Sustainability Initiatives

Family Care and other community-based, long term care programs currently serve over 44,000 individuals in Wisconsin. These are people who are both financially and functionally eligible to receive benefits. About 75% of individuals served within these programs are individuals who have a developmental or physical disability, while 25% of individuals are frail elderly enrollees.

Over the past several decades, the payments of long-term care services have shifted from individuals to the taxpayers. Nationally, the largest payer of all long-term care services is Medicaid at 42% of total spending.

While the largest payer of services is the American taxpayer, the majority of long-term care services are actually provided on an unpaid basis through a person's natural support system by their family or friends.

Each year, Wisconsin's Medicaid program spends almost $3.0 billion in long term care, supports, and other services. It is vitally important that the Department ensure that Family Care and its related programs are fiscally sustainable. Moreover, Wisconsin is facing significant growth in the number of people needing long term care. Finding solutions now that can be sustained for years to come is a priority for the Department and the Governor.

In its April 2011 evaluation of the Family Care program, the Wisconsin Legislative Audit Bureau posed critical questions regarding the fiscal sustainability and cost-effectiveness of Family Care and Wisconsin's other LTC programs and identified the need to implement strategies to reduce costs, increase efficiency and improve outcomes. The Governor's recommendation and legislative action to temporarily slow enrollment into Family Care and other long term care programs was designed to give the Department and state policymakers an opportunity to explore strategies and identify options that are fiscally sustainable and cost-effective.

A primary goal of the LTC Sustainability Initiatives is to ensure that Family Care, IRIS and other LTC benefits provide the types of services that are truly needed with the right amount of care, at the right place, and at the right time. Ultimately, that is the essence of an efficient and cost-effective long-term care program. It is also important to support services that help individuals live and work in integrated settings in their own communities.

The LTC Sustainability Initiatives are designed to support the ability of people to live and work in the most integrated and least restrictive settings. For most, that is to remain safe and cared for in their own homes and to work in integrated settings in their own communities. In analyzing existing data on our LTC programs, surveying future enrollees, and seeking input from a wide variety of consumers, stakeholders, and interested parties, options were developed to strengthen Wisconsin's Family Care and IRIS programs and better positions them for the future. These options include:

- Supporting living well at home and in the community;
- Promoting care in more integrated residential settings;
- Enhancing IRIS and self-directed supports and providing greater program integrity;
- Enhancing programs for youth in transition;
- Strengthening employment supports;
- Realigning Family Care benefits; and
- Ensuring Family Care administrative and program efficiencies.

The detailed Sustainability Initiatives can be found on the Department's website at the following address: http://www.dhs.wisconsin.gov/ltcreform/